UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Trizivir (abacavir/lamivudine/zidovudine**)**

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext.and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES

CRITERIA:

- **DOCUMENTED** failure of all three individual medications, Abacavir, Lamivudine, Zidovudine

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician or pharmacy

8/9/6